

APPENDIX A-4:

Data Abstraction Tool: Cesarean Section (MAT-4)

INSTRUCTIONS: Hospitals must refer to the appropriate version of data dictionary for abstraction guidelines that apply to this measure. Use of ***italic and underlined font*** throughout this tool indicates updated text has been inserted. The capital letters in parenthesis represents the field name that corresponds to the data element name.

1. Provider Name (PROVNAME) _____
2. Provider ID (PROVIDER-ID) _____ (AlphaNumeric)
3. First Name (FIRST-NAME) _____
4. Last Name (LAST-NAME) _____
5. Birthdate (BIRTHDATE) ____ - ____ - ____
6. Sex (SEX) ☐ Female ☐ Male ☐ Unknown
7. Postal Code What is the postal code of the patient's residence? (POSTAL-CODE) _____
(Five or nine digits, HOMELESS, or Non-US)
8. Race Code - (MHRACE) (Select One Option)
 - ☐ R1 American Indian or Alaska Native
 - ☐ R2 Asian
 - ☐ R3 Black/African American
 - ☐ R4 Native Hawaiian or other Pacific Islander
 - ☐ R5 White
 - ☐ R9 Other Race
 - ☐ UNKNOWN Unknown/not specified
9. Ethnicity Code - (ETHNICODE) _____
(Alpha 6 characters, numeric is 5 numbers with – after 4th number)
10. Hispanic Indicator- (ETHNIC)
 - ☐ Yes
 - ☐ No
11. Hospital Bill Number (HOSPBILL#) _____
(Alpha/Numeric – field size up to 20)
12. Patient ID (i.e. Medical Record Number) (PATIENT-ID) _____ (Alpha/Numeric)
13. Admission Date (ADMIT-DATE) ____ - ____ - ____
14. Discharge Date (DISCHARGE-DATE) ____ - ____ - ____
15. What was the patient's discharge disposition on the day of discharge? (DISCHARGDISP) (Select One Option)
 - ☐ 01 = Home
 - ☐ 02 = Hospice- Home
 - ☐ 03 = Hospice- Health Care Facility
 - ☐ 04 = Acute Care Facility
 - ☐ 05 = Other Health Care Facility
 - ☐ 06 = Expired
 - ☐ 07 = Left Against Medical Advice / AMA

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☐ 08 = Not Documented or Unable to Determine (UTD)

16. What is the patient's primary source of Medicaid payment for care provided? (PMTSRCE)

<input type="checkbox"/> 103	Medicaid (includes MassHealth)	<input type="checkbox"/> 282	BMC- MassHealth CarePlus
<input type="checkbox"/> 104	Medicaid Managed Care – Primary Care Clinician (PCC) Plan	<input type="checkbox"/> 283	Fallon- MassHealth CarePlus
<input type="checkbox"/> 108	MCD Managed Care - Fallon Community Health Plan	<input type="checkbox"/> 284	NHP- MassHealth CarePlus
<input type="checkbox"/> 110	MCD Managed Care - Health New England	<input type="checkbox"/> 285	Network Health- MassHealth CarePlus
<input type="checkbox"/> 113	MCD – Neighborhood Health Plan	<input type="checkbox"/> 286	Celticare- MassHealth CarePlus
<input type="checkbox"/> 118	MCD Managed Care - Mass Behavioral Health Partnership Plan	<input type="checkbox"/> 287	MassHealth CarePlus
<input type="checkbox"/> 207/274	MCD Managed Care- Network Health (Cambridge Health Alliance)	<input type="checkbox"/> 119	Medicaid Managed Care Other
<input type="checkbox"/> 208	MCD Managed Care - HealthNet (Boston Medical Center)	<input type="checkbox"/> 178	Children's Medical Security Plan (CMSP)

17. What is the patient's MassHealth Member ID? (MHRIDNO)

_____ (All alpha characters must be upper case)

18. Does this case represent part of a sample? (SAMPLE)

- ☐ Yes
☐ No

19. ICD-9-CM Principal or Other Diagnosis Codes (Table 11.09)

- ☐ At least one on Table 11.09 (Review Ends)
☐ None on Table 11.09

20. ICD-9-CM Principal or Other Diagnosis Codes (Table 11.08)

- ☐ None on Table 11.08 (Review Ends)
☐ At least one on Table 11.08

21. Was the patient involved in a clinical trial during this hospital stay relevant to the measure set for this admission (CLNCLTRIAL)

- ☐ Yes (Review Ends)
☐ No

22. What was the infant's gestational age at the time of delivery? (GESTAGE)

Weeks: ____ (in completed weeks; do not round up)(enter 2 digit numeric value with no leading 0, or UTD)

UTD ____ (if UTD or if gestational age is <37 weeks, Review Ends)

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23. How many deliveries did the patient experience prior to current hospitalization? (PARITY)

_____ (if > 0 or UTD (Review Ends))

24. ICD-9-CM Principal or Other Procedure Codes (Table 11.06)

- ☐ None on Table 11.06
- ☐ At least one on Table 11.06